SUGGESTED FORM

Mental Retardation Community Medicaid Services

INDIVIDUAL SERVICE PLAN

60-DAY ASSESSMENT

Indicate Service: _____Residential Support _____Supported Employment _____ Prevocational
_____Personal Assistance _____ Day Support

ESTIMATED DURATION: **NOT TO EXCEED 60 DAYS**

Individual:_____Medicaid Number:_____

Code:_____ Provider Name:_____Provider Number:_____

Responsible Staff (name or position of implementer of the plan):_____

Start Date:_____End Date:_____ Quarterly Review Dates: _____ _____ _____ _____

CSP SELECTED GOAL/ DESIRED OUTCOME:

OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES

Individual:_____Service:_____ Start Date:_____

OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES

Individual:_____ Service:_____ Start Date:_____

OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES

Individual:_____ Service:_____ Start Date:_____

TOTAL HOURS/ UNITS PER WEEK_____

GENERAL SCHEDULE OF SERVICES

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

COMMENTS:
(Role of other agencies if plan a shared responsibility)

**Attach a signature page that includes, at a minimum, the signatures of the individual/legal guardian and the provider's responsible staff member.*